# Section H
# Other health insurance

# Alternatives to private individual Medicare and Medicare supplement

In some cases, seniors have alternatives to Medicare and Medicare supplement policies available to them. In addition, there are various specialty insurance products on the market which are often marketed to senior adults. Further discussion follows.

# Managed care

Managed care is not new. It was originally developed to provide coordinated care in a cost effective way (1973); designed to control rising costs. The definition of managed care is **health care and financing are handled by the same entity/organization.**

In April 2008, more than one in five Medicare recipients were enrolled in a Medicare Advantage plan.

Managed care organizations or plans contract with CMS to provide Medicare benefits to enrollees. Plans must provide all benefits provided by Medicare; they may provide additional benefits.

1. To qualify for a Medicare managed care plan
    - Must have both Part A and Part B of Medicare and continue paying Part B premium
    - Must live in the area served by the plan (designated by county or ZIP code)
    - Must not be receiving hospice care (can choose if already covered by plan)
    - Must not have end stage renal disease (plan must cover care if already enrolled)

2. How it works
    - You may be charged a copayment for doctor visits or other services.
    - The plan coordinates bills and payments.
    - Managed care plans cannot refuse to enroll you because of health, disability or most pre-existing conditions (except those above)
    - Managed care plans must have at least one 30-day open enrollment period each year. Many offer continuous open enrollment.
    - Plans generally cover all Medicare Part A and B services; however, there is generally a different cost share than Medicare.

3. Costs
    - Medicare Part B premium
    - Monthly premium for the managed care plan if there is one
    - Copayments for services if required

NOTE: Managed care plans often offer preventive benefits and other services that are not covered by Medicare, e.g., prescription drugs*, vision, dental.

**Most plans have some type of limit on the amount of drugs that will be covered.*

4. Managed care plan benefits and costs may change from year to year.

5. Summary
Under a Medicare managed care plan you may pay lower costs and receive additional benefits in return for

agreeing to see the physicians and use the facilities on the plan's list. Additionally, not all facilities may accept these plans as a form of payment (i.e. Medicare Advantage, PFFS). If you enroll in a managed care plan and later decide to disenroll, you may have difficulty finding a private Medicare supplement. There are some circumstances that may allow you to enroll in certain Medicare supplement plans without difficulty.

# Medicare Advantage

All Medicare beneficiaries everywhere continue to have access to original Medicare and private Medicare supplement (though open enrollment is limited). If you are happy with your current arrangements, you do not need to change.

**Medicare options**

- Original Medicare/Medicare supplement OR
- Medicare Part C (alternatives to Medicare or Medicare Advantage plans)
    - Health maintenance organization (HMO)
    - Provider sponsored organization (PSO)
    - Preferred provider organization (PPO)
    - Private fee for service (PFFS)
    - Medical savings account (MSA)

1. **Medicare HMO** must provide the same benefits available with original Medicare. Beneficiary agrees to use providers who are part of the HMO network.

You choose a primary care physician (PCP) who coordinates your care. The PCP must authorize your care (including hospitalization and specialist care). If you receive other than emergency or urgent care outside the network, neither the plan nor Medicare will pay. In exchange for these restrictions, beneficiaries (usually) receive more benefits and lower costs (Medicare supplement not necessary).

- You enroll in the managed care plan.
- Generally, you select a primary care physician from the plan's list of providers. The primary care physician in the managed care plan who coordinates the care is called the gate keeper.
- Generally, your care is coordinated by the gatekeeper—he or she must refer you to specialists if needed. Without a referral, the plan generally won't pay.
- Case management is also provided in managed care plans. The case management consists of all medical info being filed into one chart per patient for the gate keeper's review and coordination.

2. **Provider sponsored organization (PSO)** is a group of doctors and hospitals that form their own organization to enroll and treat Medicare beneficiaries. Works like an HMO in that you agree to receive care within the network.

3. **Preferred provider organization (PPO)** is a network of providers set up by the health plan. If you choose to go to providers not in the network, the plan will pay less of the cost; you are responsible for the rest.

4. **Private fee for service (PFFS)** is a private insurance policy that pays providers for each service. You receive services from any provider that accepts the plan's terms and conditions. The PFFS plan covers the cost of your care according to its own fee schedule.

You pay a monthly premium in addition to the Part B premium. There are no limits on how much the plan can charge in premium.

Cautions for private fee for services plans:

- Does not work as a supplement
- Not all doctors and hospitals accept
- Copays for each service will apply

5. **Medicare medical savings accounts (MSA)** plans cover all Medicare Part A and Part B benefits. MSA plans may also cover additional benefits for an extra cost. Enrollees still have to pay the Part B premium.

Members in an MSA plan will receive an annual deposit into an interest-bearing account from CMS to help them cover their health care costs. Members can use these funds to pay for medical services. When the money in the account is used to cover qualified medical expenses under IRS rules, it is not taxed.

Once a member has reached his/her deductible, the plan is responsible for all Medicare-covered costs. Any amount of the deposit that is left at the end of the year remains the property of the member and can be used to cover health care costs the following year. MSA plans are statutorily restricted from covering Part D drugs, but MSA enrollees can join a stand-alone prescription drug plan (PDP).

**MSA plan offerings in 2009**
Below is a summary of the key benefits to be offered in the 2009 MSA plans:

6. **Medicare cost plan**

A Medicare health plan is a plan that was made available through Section 1876 of the Social Security Act and has been around since the 1990s. The organization offering the plan is not at financial risk for the costs of their members. This is different than a Medicare Advantage plan where the plan has total financial responsibility.

The Medicare beneficiary is required to seek services from the cost plan's network of providers and follow the rules of the cost plan (i.e., referral process and utilization management) in order to receive benefits. The cost plan is available in limited geographical areas. If a person in a Medicare cost plan goes to a non-network provider, the services are covered under the original Medicare plan. The beneficiary would have to pay the Medicare Part A and B deductibles and coinsurance. People can join a Medicare cost plan anytime it is accepting new members and can leave the Medicare cost plan at any time to return to original Medicare.
By a Medicare beneficiary choosing a cost plan, the benefits of a cost plan are sometimes enhanced. They generally offer more preventive care, extras such as vision, hearing, and/or dental and lower cost sharing (copays and coinsurance). The cost plan has an extra monthly premium, which a person would need to measure out for the exchange of the additional benefits. Also, the beneficiary should keep in mind that their quantity of healthcare can be limited.

The member can either get their prescription drug coverage from the Cost Plan, if offered, or get a stand-alone prescription drug plan. Currently, there are five cost plans offered in North Dakota (2008).

## Retirement plans

Group insurance coverage is a common employment benefit. Some companies may continue to provide health insurance coverage to retired employees.

1. Employment related plans are individualized for each company or organization and vary widely. There are no set standards they must meet.

2. Employer retirement plans may offer benefits that supplement Medicare and work secondary to Medicare or replace Medicare.

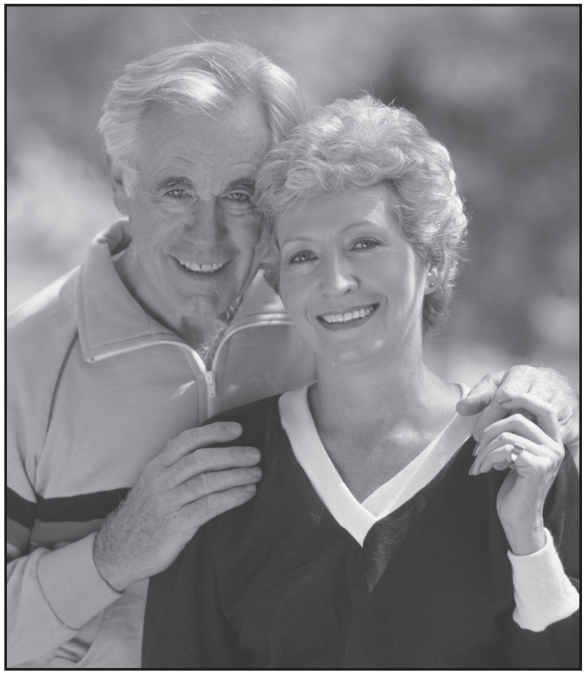
3. Employer retirement plans do not have to conform to state or federal Medicare supplement rules.

4. Employer plans may change or even eliminate retirement benefits due to increasing costs or other factors.

5. If a company self insures, the coverage is not actually an insurance policy and is not regulated by the Insurance Department. The Department of Labor regulates self-insured plans under Employee Retirement Information and Security Act (ERISA) regulations. A company that self-insures is covering employees' health care claims from the company's assets/profits.

6. If an employer health insurance plan is available to you after retirement, here are some questions and issues to consider:

A. Does the plan appear to be secure or is the employer cutting back on benefits?
B. Does the plan cover the retired person's spouse or other dependents?
C. Will the spouse/dependent be covered if the retired person dies?
D. Are there lifetime maximums in the employer's plan? If so, how much of them have been used?
D. What are the deductibles or copayments of the employer's plan?
F. Does the employer plan provide dental, vision, hearing or other coverage?
G. Does the employer plan require use of certain providers?
H. Does the plan cover prescription drugs?
I. How much does the plan cost per month? How does this compare to Original Medicare?



7. To fully analyze an employer plan, you must review a current copy of the plan's benefit booklet. This can be obtained and additional questions answered by human resource department staff or an employee benefit coordinator.

8. For assistance with claims resolution for self-insured plans, North Dakotans may call the Kansas City regional office of the Department of Labor at (816) 426-5131 (nationwide toll-free 866-444-3272) or they may write:

Employee Benefits Security Administration
U.S. Department of Labor Regional Office
City Center Square, Suite 1200
1100 Main Street
Kansas City, MO 64105

9. **The Dakota Retiree Plan** is health coverage provided by the State of North Dakota for the following members who are receiving a retirement allowance from:

- North Dakota Public Employees Retirement System (NDPERS)
- North Dakota Highway Patrol Retirement System (NDHPRS)

- Job Service Retirement Plan
- Teachers Fund for Retirement (TFFR)
- Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA-CREF)

The NDPERS/Dakota Retiree Plan is a carve out plan that pays secondary to Medicare. It is NOT a supplemental plan. A carve out plan pays a limited portion of what Medicare does not pay.

A member or eligible dependent may enroll in this health coverage at the time of Medicare eligibility.

The eligible member MUST HAVE MEDICARE PARTS A AND B.

The eligible member DOES NOT need to take out a Medicare Part D plan. The NDPERS/Dakota Retiree Plan DOES have a drug component.

## Group policies

A group policy is a contract between the insurance company and an organization, usually an employer or association. (An individual policy is a contract between one person, the policyholder and an insurance company).

1. The organization has a master contract and is the policyholder.
    A. The organization enrolls members or employees who become **certificate holders**.
    B. The price of group coverage is often—but not always—lower than similar coverage in an individual contract.
    C. Group policyholders can—and do—make changes in their contracts which affect certificate holders. For example, the group policyholder might decide to switch companies or simply to stop offering members anything.

2. When the group plan ends
    A. When an employer terminates a group plan, the insurance company may make a conversion option available to employees. A conversion option is where the employees may have the option of converting to an individual plan of insurance.

3. When the group switches
If the group policyholder switches insurance companies, the new company must offer coverage to everyone who was covered under the old group policy, with continuous coverage and no new conditions. All preexisting conditions covered under the old contract must be covered under the new contract. However, the new policy might (and probably will) have different benefits.
4. When one spouse is Medicare eligible
    A. If a Medicare-eligible individual is covered under a working spouse's employer group plan, and employment ends or the plan is terminated, the Medicare eligible spouse would enroll in Medicare and have their six-month open enrollment period in Medicare supplement.
    B. If the group carrier offers Medicare supplement insurance, they might provide a conversion option (i.e., allow the Medicare eligible spouse to convert from the group coverage to a Medicare supplement plan).

## Limited benefit plans

There are a number of other types of insurance policies available to senior adults. These may or may not be

appropriate purchases. All should be evaluated carefully with consideration given to cost vs. benefits provided and if those benefits are part of other coverage the client has.

Policies must contain a disclosure statement about duplicate Medicare coverage.

## APPENDIX C

## DISCLOSURE STATEMENTS
### Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries That Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**
**THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when it pays:**

• hospital or medical expenses up to the maximum stated in the policy

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

• hospitalization
• physician services
• [outpatient prescription drugs if you are enrolled in Medicare Part D]
• other approved items and services

**Before You Buy This Insurance**

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

# Other health insurance exercise

1. Managed care was developed to help control the rising costs of healthcare. T____ F ____

2. Managed care includes the health care and financing in the same benefit. T____ F ____

3. Name the four criteria to qualify for a managed care plan.

a.

b.

c.

d.

4. You do not need to purchase Part B with managed care. T____ F ____

5. Managed care plans traditionally offer preventative services and other services not covered by Medicare (i.e. prescription drugs, vision, dental, hearing, etc.) T____ F ____

6. What are the different Medicare Advantage plans? Briefly describe each one.

a.

b.

c.

d.

e.

f.

7. HMOs do not cover emergency care outside the HMO's network. T____ F ____

8. What are some cautions about a private fee for service plan?

a.
b.
c.

8. All retiree plans are standardized. T____ F ____

9. The _____ is a retirement health plans available to Medicare beneficiaries who were employed by the State of ND and paid into the Public Employees Retirement System.

# Matching

_____ Preferred provider network
_____ Health maintenance organization
_____ Gatekeeper
_____ Case management
_____ Disclosure statement
_____ Private fee for service

a. Beneficiary agrees to use a HMO network. If care is received other than emergency, neither the plan or Medicare will pay.

b. This term consists of all medical information being filed into one chart per patient for the gatekeeper's review and coordination.

c. Statement which tells how the benefits of a limited benefit plan may duplicate Medicare coverage.

d. A network provider that is set up by a health plan. If you chose to go to providers not in the network, the plan will pay less of the costs and you are responsible for the rest.

e. A private insurance policy that pays providers for each service. The provider must accept the plans terms and conditions. This type of plan covers the cost of cares on their own schedule.

f. A primary care physician in the managed care plan who coordinates a beneficiary's care.